Electronic Adjustments

With the implementation of HIPAA compliant claim formats, adjustments can now be filed electronically, regardless of claim type and original claim format. Filing adjustments electronically results in quicker resolution and correct payment. Electronic adjustments are submitted in the form of claim voids and replacements:

Professional (CMS-1500) and Dental (ADA) void and replacement claims are filed using the Claim Submission Reason Indicator. A value of 7 indicates a replacement claim and a value of an 8 indicates a void claim. Institutional (UB-92) void and replacement claims are filed based on the third digit of the Type of Bill on the claim. Institutional providers use a value of 7 to indicate a replacement claim and a value of an 8 to indicate a voided claim.

Listed below are examples of each of the adjustment types that may be submitted:

Void Claim

When a provider submits a claim as a void, the system searches for the original ICN (indicated on the void claim) to recoup any and all previous payment.

Example: A provider mistakenly files a claim for an office visit for Mr. Smith. The claim should have been submitted for his wife, Mrs. Smith. The claim for Mr. Smith is received, processed, and paid by Medicaid. The provider notices the billing error when the RA is received and shows payment made for Mr. Smith. The provider can have the original claim voided by resubmitting the original claim changing the Claim Submission Reason 8 including the original ICN from the RA showing payment for Mr. Smith.

Replacement Claim

When filing a replacement claim, include Claim Submission Reason Indicator 7, the original ICN of the previously processed claim, and corrected claim information. The claim associated with the original ICN will be recouped and the corrected claim will be processed in its place. If for any reason the corrected claim denies, the previously processed claim will not be recouped.

Example: A provider bills for one 15 minute unit of therapy when 1 hour of therapy (four 15 minute units) should have been billed. Medicaid processes and pays the original claim for one 15 minute unit. The provider notices the billing error when the RA is received and shows payment made for one 15 minute unit. If the provider billed for the balance of the missing units, the claim would likely deny as a duplicate. Instead, a corrected claim for the entire four 15 minute units can be submitted, with Submission Reason code 7 and the ICN from the original claim. The system will recoup the original claim and process the correct claim for four units.

Reminder: Void and replacement adjustments can only be performed on paid claims. Denied claims do not require adjustment; simply correct the errors indicated by the Explanation of Benefits code (EOB) and resubmit the claim.

Questions regarding these types of adjustment can be addressed by EDS Provider Services at 1-800-688-6696, select option 3 from the menu.